

County/Direct Provider Approver Certification

ADP 100121(Rev 12/05)

ADP Approved (ADP use only)DateApprover

For Access to Confidential ADP Drug Medi-Cal Information Data

County: _____
(County Name and Code)**Direct Provider:** _____
(Direct Provider Name and Four Digit DMC Number(s))

To ensure the confidentiality of county/direct provider Drug Medi-Cal (DMC) data, the Department of Alcohol and Drug Programs (ADP) requests the County ADP Administrator or Direct Provider Executive Officer designate a primary and a secondary contact to be responsible for approving county/direct provider staff requests for access to confidential patient data in the Short-Doyle / Medi-Cal Claims – EOB system. Please complete the information below and fax this form to (916) 323-0653. If you have questions about this form, please call (916) 323-2043.

Primary Approver:

| | |
|------------------------------------------------------------------------------------------------------------|-------------------------|
| First Name: _____ | Last Name: _____ |
| Title: _____ | |
| Phone Number: () _____ | Fax Number: : () _____ |
| Email Address: _____ | |
| Primary Approver's Signature: _____ | |
| (Signer acknowledges having read the attached Confidentiality Statement for all ADP AOD users of the ITWS) | |

Secondary Approver:

| | |
|------------------------------------------------------------------------------------------------------------|-------------------------|
| First Name: _____ | Last Name: _____ |
| Title: _____ | |
| Phone Number: () _____ | Fax Number: : () _____ |
| Email Address: _____ | |
| Secondary Approver's Signature: _____ | |
| (Signer acknowledges having read the attached Confidentiality Statement for all ADP AOD users of the ITWS) | |

Appointed Vendor(s): (If applicable)

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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| The vendor listed below has the authority to receive, send and process the above named county/direct provider's confidential ADP Drug Medi-Cal information in the Short-Doyle / Medi-Cal Claims – EOB system. The vendor will establish its own primary and secondary approving contacts. | |
| Vendor Name: _____ | |
| Vendor Contact Name: _____ | Phone Number: () _____ |

System(s):

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|--------------------------------------------------------------------------------|
| <input type="checkbox"/> Short-Doyle / Medi-Cal Claims – EOB (SDMC-EOB) |
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ADP Administrator/Executive Officer Certification:

As the ADP Administrator or Executive Officer for _____ (County/Direct Provider), I designate the above individuals and vendor, if applicable, to have independent authority to approve access requests to specific confidential Drug Medi-Cal patient data. ADP may rely on approvals, denials, and changes made by the above individuals/vendor in its processing of access requests to this county/direct provider's data in the systems listed above. As changes occur to the above approving contacts or vendor information (name, phone, e-mail, or fax), I will sign an updated certification and forward it to ADP. Also, I acknowledge reading the Confidentiality Statement for all ADP AOD users of the ITWS.

Alcohol & Drug Administrator/Executive Officer (signed and printed)

Date